STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155446	B. WIN			03/12/	/2013
NAME OF B	DOLUDED OD GUDDI IE	D.	•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	K		5700 V	VILKIE DR		
	TON MANOR HEA	LTH AND REHABILITATION CEN	ΓER	FORT	WAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
K010000							
	A Life Sefety C	ode Recertification and	L VO	10000	K0000: *This Plan of		
	_		I Ku	10000	K0000: *This Plan of Correction is the center's cred	ihle	
		Survey with a PSR for the			allegation of	1010	
		nce Walk-thru Survey			compliance.		
		0/31/12 was conducted by			*Preparation and/or execution		
		e Department of Health in			this plan of correction does no	t	
	accordance with	n 42 CFR 483.70(a).			constitute admission or	.l	
	Survey Date: 0.	3/12/13			agreement by the provider of truth of the facts alleged or conclusions set forth in the		
	T 1137 N 1	000476			statement of deficiencies. The plan of correction is prepared	2	
	Facility Number				and/or executed solely because	se it	
	Provider Number				is required by the provisions of		
	AIM Number:	100290870			federal and state law.		
	Surveyor: Amy Specialist	Kelley, Life Safety Code					
	At this Life Safe	ety Code survey,					
	Covington Man						
	_	Center was found not in					
		h Requirements for					
	-	_					
	-	Medicare/Medicaid, 42					
	-	33.70(a), Life Safety from					
		00 edition of the National					
		Association (NFPA) 101,					
	_	le (LSC) and 410 IAC					
		nal building consisting of					
	_	East wing, Bed and					
	Breakfast unit a	nd the service hall was					
	surveyed with C	Chapter 19, Existing					
	Health Care Occ	_					
		-					
	This one story f	acility was determined to					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

WXVN21

Facility ID:

TITLE

(X6) DATE

	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155446		LDING	NSTRUCTION 01	(X3) DATE COMPL 03/12/	ETED	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors with battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 116 at the time of this survey. The facility was found in compliance with state law in regard to smoke detector coverage and sprinkler coverage. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLI	
		155446	B. WIN	G		03/12/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER		'ILKIE DR WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG K010025 SS=D	NFPA 101 LIFE SAFETY CO Smoke barriers a least a one half haccordance with 8 terminate at an af protected by fire- glass panels and of two separate c on each floor. Da duct penetrations ducted heating, v conditioning syste 19.1.6.3, 19.1.6.4 Based on observ facility failed to smoke barriers w a one half hour f LSC 8.3.2 requi be continuous fro outside wall. Th could affect 1 res Breakfast unit.	DDE STANDARD re constructed to provide at our fire resistance rating in 8.3. Smoke barriers may trium wall. Windows are rated glazing or by wired steel frames. A minimum ompartments are provided mpers are not required in of smoke barriers in fully entilating, and air ems. 19.3.7.3, 19.3.7.5, ation and interview, the ensure 1 of 1 ceiling was maintained to provide are resistance rating. res smoke barriers shall om an outside wall to an anis deficient practice sident in the Bed and	K01	0025	K0025: *The facility will ensur ceiling smoke barriers are maintained to provide a one had hour fire resistant rating. *Oth residents have the potential to affected. The hole in the close room 401 has been repaired to comply with regulation. *Maintenance staff has completed a thorough review of all areas in the facility to ensur there are no additional similar areas out of compliance.	alf er be et of O	DATE 03/21/2013
	Findings include Based on an obse				Maintenance will add this visual check and follow up to their monthly building review for	al	
	Maintenance Dir	rector on 03/12/13 at			compliance. * Results of		
	· · · · · · · · · · · · · · · · · · ·	e is a one and one half			monthly checks will be brough the facility monthly QA&A	t 10	
		ceiling next to the			committee for review and follow	w	
	sprinkler head in	the closet of resident			up for a minimum of 6 months		
	room 401 in the	Bed and Breakfast unit.			and until the facility sustains a		
	The measuremen	nt was provided by the			consistant pattern of complian		
	Maintenance Dir	rector at the time of			with a subsequent plan develo and implemented as necessar		
	observation.				and implemented do nococour	,· 	
	3.1-19(b)						

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Event ID: WXVN21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		ILDING	NSTRUCTION 01	COM	E SURVEY PLETED 2/2013			
COVING ⁻		LTH AND REHABILITATION CEN	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXVN21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	LDING	01	(X3) DATE S COMPL 03/12/	ETED	
		133440	B. WIN			03/12/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		/ILKIE DR WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K010038 SS=E	readily accessible with section 7.1. Based on observe facility failed to was accessible, permit delayed-econditions of LS met. LSC 7.2.1.0 irreversible processible processibl	anged so that exits are at all times in accordance 19.2.1 ation and interview, the ensure 1 of 10 exit doors Health care occupancies ogress locks if all the C, Section 7.2.1.6.1 are 6(c) requires an ess shall release the lock als upon application of a use device. This deficient offect any residents of the service hall from the event of an main dining room had residents.	K0	10038	K038: *The facility will continue to ensure exit doors are accessible. *The facility's sectompany has reset the door to the service hall to comply with second release requirement. *The door is a entry way to the facility's service hall where all deliveries are received and is typically used for evacuation. Should the dining room have to be evacuated in an emergence exit door in the dining room conton be used in that instance. Maintenance staff will monitor release on the door daily 5x/w for 2 weeks, 1x/weel for 2 weeks then monthly going forward to ensure compliance. *Results monitoring will be brought to the facility QA&A committee month for a minimum of 6 months and until the facility has sustained consistant pattern of compliant with a subsequent plan development of the property of the facility has sustained consistant pattern of compliant with a subsequent plan development of the property of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained consistant pattern of compliant with a subsequent plan development of the facility has sustained the f	urity 15 2 not y an puld the eek eks s of ne hly d a ce opped	03/21/2013
	3.1-19(0)						

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PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155446	(X2) MULT A. BUILDIN B. WING		01 	COMPL 03/12	LETED		
COVING		TH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155446	A. BUII B. WIN			03/12/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER		ILKIE DR WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010039 SS=E	unobstructed) ser least 4 feet. 19 Based on observer facility failed to corridors had a creat width of at least 4 width of at least 4 feet. This deficient processed from the market of an emer room had chairs Findings include Based on an observation of the cardboard width of the corresponding to the cardboard width of the cardboar	corridors (clear and ving as exit access is at .2.3.3 ation and interview, the ensure 1 of 10 exit access clear and unobstructed east 4 feet (48 inches). actice could affect any ted through the service in dining room in the gency. The main dining to seat 26 residents. Everytion with the rector and the Director of Services on 03/12/13 at the were cardboard boxes revice hall. At least seven boxes were stored so the ridor measured thirty easurements were Maintenance Director at roation. The rector and the Director of Services confirmed the used as an emergency	K01	0039	K039: *Exit access corridors version have a clear and unobstructed exit width of at least 48 in. *The cardboard boxes were removed from the service hall. This corridor is used for delivery of supplies. In case of a need for evacuation of residents in the dining room the exit door in the dining room could be used. *Maintenance and environmental services staff we promptly distribute supplies up delivery. The Administrator with monitor daily 5x/week for 1 monitor daily 5x/week for 1 monitor daily monitoring will be brout to the monthly QA&A committee for review and follow up for a minimum of 6 months and untite facility has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessarial.	e dd fee ill on ll onth ts ght ee l ce ped	03/21/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPL	ETED
		155446	B. WIN			03/12/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ILKIE DR		
COVING ⁻	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010050 SS=F	under varying cor on each shift. The procedures and is of established rouplanning and comonly to competent to exercise leader conducted between announcement maudible alarms. Based on record facility failed to conducted quarter the last 4 completed deficient practice occupants. Findings include Based on review Report" with the 03/12/13 at 1:15 of a third shift finduarter of 2012, with the Mainter of record review	d at unexpected times inditions, at least quarterly e staff is familiar with a aware that drills are part utine. Responsibility for ducting drills is assigned it persons who are qualified riship. Where drills are en 9 PM and 6 AM a coded any be used instead of 19.7.1.2 review and interview, the ensure fire drills were enly on each shift for 1 of eted quarters. This is a could affect all The drill is a could affect all is a could affect all The drill is a could affect all is a could affect	K0	10050	K050: *The facility will ensur fire drills are conducted quarte on all three shifts. *All residents have the potential to affected. The maintenance stawill conduct fire drills ensuring drill on each shift is done each quarter. *The Administrator will review fire domonthly going forward to ensure compliance. *Results monthly monitoring will be brought to the facility monthly QA&A committee for review are follow up for a minimum of 6 months and until the facility has sustained a consistant pattern compliance with a subsequent plan developed and implement as necessary.	be aff a rills re of	03/21/2013

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		ILDING	NSTRUCTION 01	COM	E SURVEY PLETED 2/2013			
COVING ⁻		LTH AND REHABILITATION CEN	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	LDING	01	(X3) DATE S COMPL 03/12/	ETED
ROVIDER OR SUPPLIER						
TON MANOR HEAL	TH AND REHABILITATION CEN	NTER				
(EACH DEFICIEN REGULATORY OR NFPA 101 LIFE SAFETY CO	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) DDE STANDARD		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	те	(X5) COMPLETION DATE
accordance with a Based on record facility failed to extinguishing systems inspected and set NFPA 96, the St Control and Fire Commercial Cooks-2 requires an in of the fire exting every six months was not in a residual affect kitchen statemergency. Findings include Based on record Director on 03/1 Koorsen Fire and form indicated "It to be performed, stating that this is Based on interview Director at the times and the process of the statement of the process of the statement of the process of the statement of th	2.2.3. 19.3.2.6, NFPA 96 review and interview, the ensure 1 of 1 hood stems in the kitchen was rviced every six months. andard for Ventilation Protection of oking Operations, Section anspection and servicing uishing system at least s. This deficient practice dent care area but could aff in the event of an : review with Maintenance 2/13 at 1:34 p.m., the d Security inspection Regulator testing needed No label or sticker service was performed." ew with the Maintenance me of record review, he ovide documentation to	K0	10069	testing of the regulator is completed per regulation. *The regulator has been tested and in compliance with regulation. *Maintenance staff has been reminded to fully review inspection reports and promptly follow up on areas mas not completed during the inspection. Maintenance will forward to the Administrator copies of all inspections to emprompt follow up on areas not as not completed during the ir inspection. *Inspections not completed at time of initial inspection will be forwarded to monthly QA&A committee for review and follow up for a minimum of 6 months and untithe facility has sustained a consistant pattern of complian with a subsequent plan development.	ne l is coted sure ed nitial fully the a il	03/21/2013
	ROVIDER OR SUPPLIER FON MANOR HEAL SUMMARY S' (EACH DEFICIEN REGULATORY OR NFPA 101 LIFE SAFETY CO Cooking facilities accordance with 9 Based on record facility failed to extinguishing systems in spected and ser NFPA 96, the St Control and Fire Commercial Cooks-2 requires an in of the fire exting every six months was not in a reside affect kitchen state emergency. Findings include Based on record Director on 03/1. Koorsen Fire and form indicated "It to be performed, stating that this is Based on intervice Director at the times and the regular confirm the regular confirmation of the summable to preconfirm the regular confirmation of the summable to preconfirmation of the summabl	ROVIDER OR SUPPLIER FON MANOR HEALTH AND REHABILITATION CENTS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice was not in a resident care area but could affect kitchen staff in the event of an emergency. Findings include: Based on record review with Maintenance Director on 03/12/13 at 1:34 p.m., the Koorsen Fire and Security inspection form indicated "Regulator testing needed to be performed. No label or sticker stating that this service was performed." Based on interview with the Maintenance Director at the time of record review, he was unable to provide documentation to confirm the regulator had been tested.	ROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. 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ROVIDER OR SUPPLIER FON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.32.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and servicing of the fire Protection of Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing was not in a resident care area but could affect kitchen staff in the event of an emergency. Findings include: Based on record review with Maintenance Director on 03/12/13 at 1:34 p.m., the Koorsen Fire and Security inspection form indicated "Regulator testing needed to be performed. No label or sticker stating that this service was performed." Based on interview with the Maintenance Director at the time of record review, he was unable to provide documentation to confirm the regulator had been tested.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED		
		155446	A. BUII B. WIN			- 03/12/2013		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	NAME OF PROVIDER OR SUPPLIER							
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER	5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K010104 SS=E	protected in acco Based on observ facility fail to en penetrations was damper. LSC 10 an approved dam passage of smok each air transfer penetration of a r This deficient pr resident on east l Findings include Based on observ Maintenance Dir p.m., a smoke da the ventilation de attic smoke barri near resident roo acknowledged by	moke barriers by ducts are rdance with 8.3.6. ation and interview, the sure 1 of 1 east hall duct provided with a smoke 11 section 8.3.5.1 states aper designed to resist the e shall be provided for opening or duct required smoke barrier. actice could affect all 22 hall.	KO	10104	K104: *The facility will ensure hall duct penetrations be proving with a smoke damper. *All residents have the potential to affected. The facility contacte contractor to install the smoke damper and it was determined the contractor a smoke damper was already present in the ventilation duct near room 307 and was present at the time of this survey. see attached *Maintenance staff will ensure dampers are included on the lof dampers and will be inspectively 4 years to ensure compliance. *Maintenance staff will monitor every 4 year inspection of dampers to ensure all dampers are inspected to ensure compliance.	ded be d a d by er f all ist ted	03/13/2013	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		01		(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
		155446	B. WIN	G		03/12/2	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					VILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER	FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010147	NFPA 101	DE CTANDADD					
SS=D	LIFE SAFETY CO						
	•	ind equipment is in NFPA 70, National					
	Electrical Code. 9						
		ation and interview, the	K0	10147	K147: *The facility will ensure		03/21/2013
		ensure 1 of 1 flexible		/	flexible cords such as extension		
	_	extension cord was not			cords not be used as a substit		
		ute for fixed wiring. LSC			for fixed wiring. *The extension		
		ectrical wiring and			cord was removed. Staff have been reminded not to bring	,	
	•	nply with NFPA 70,			extension cords into the		
		cal Code, 1999 Edition.			facility. *The maintenance staf	f	
		·			will monitor all areas of the fac	ility	
	•	e 400-8 requires, unless			monthly to ensure compliance		
		nitted, flexible cords and			The administrator will visually check all non resident areas a		
		be used as a substitute			minimum of 1x/month to ensur		
	_	of a structure. This			compliance. *The results of		
	•	e was not in a resident			monitoring will be brought to the	ne	
	care area but cou	ald affect staff.			monthly QA&A committee for review and follow up for a		
	Findings include	:			minimum of 6 months and unti	il	
					the facility has sustained a consistant pattern of complian	се	
	Based on an obse				with a subsequent plan develo		
		rector on 03/12/13 at			and implemented as necessar	y.	
		avy duty extension cord					
	was plugged in a	and providing power to a					
	desk top comput	er in the Director of Staff					
	Development's o	ffice. This was					
	acknowledged by	y the Maintenance					
	Director at the ti	me of observation.					
	3.1-19(b)						
	. ,						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. BUILDING 01		COMPLETED		
		155446	B. WING			03/12/2013	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
COVINGTON MANOR HEALTH AND REHABILITATION CENT							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
K020000							
K020000	ON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES		K02	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		of t he	
		cility was determined to 1) construction and was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			BUILDING 02			(3) DATE SURVEY COMPLETED 03/12/2013	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors with battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 116 at the time of this survey. The facility was found in compliance with state law in regard to smoke detector coverage and sprinkler coverage. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	, NIII DDIC 02		COMPL	ETED	
		155446	A. BUILDING			03/12/2013	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
00\(IN0		THE AND DELIABILITATION OF N	5700 WILKIE DR				
COVING	ION MANOR HEAL	TH AND REHABILITATION CEN	FER FORT WAYNE, IN 46804				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
K020050	NFPA 101						
SS=F	LIFE SAFETY CO	DDE STANDARD					
		Fire drills are held at unexpected times					
		nditions, at least quarterly					
		e staff is familiar with					
	•	s aware that drills are part					
	of established routine. Responsibility for						
	planning and conducting drills is assigned only to competent persons who are qualified						
	to exercise leadership. Where drills are						
		en 9 PM and 6 AM a coded					
	announcement m	ay be used instead of					
	audible alarms. 18.7.1.2						
	Based on record review and interview, the		K020050		K050: *The facility will ensur		03/21/2013
	facility failed to ensure fire drills were				fire drills are conducted quarterly on all three shifts. *All residents have the potential to be affected. The maintenance staff will conduct fire drills ensuring a drill on each shift is done each		
	conducted quarterly on each shift for 1 of						
	the last 4 completed quarters. This						
	deficient practice could affect all						
	•						
	occupants.				quarter. *The		
					Administrator will review fire drills		
	Findings include: Based on review of the "Fire Drill Report" with the Maintenance Director on				monthly going forward to ensure		
					monthly monitoring will be		
					brought to the facility monthly		
	•	p.m., there was no record			QA&A committee for review a follow up for a minimum of 6	id	
		re drill for the third			months and until the facility ha	10	
		Based on an interview			sustained a consistant pattern		
	•	nance Director at the time			compliance with a subsequent		
					plan developed and implemen		
		, no other documentation			as necessary.		
		r review to verify this					
	drill was conduc	ted.					
	3.1-19(b)						
	3.1-51(c)						
	\						

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